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MENTAL SUS LAW KEEPS BLACK COMMUNITY UNDER CONTROL

Today, after decades of significant Black presence in Britain, the effective British propaganda machine still grinds on depicting BLacks as losers, stupid, thick, subservient, trouble makers, hostile, aggressive. Negative stereotypical images of Black people resound through British culture, reinforced by immigration laws used as a standard solution to race issues. Immigration/Nationality Acts appear with uncanny regularity after significant racial tensions as do Mental Health Acts. The rationale behind the Immigration/Nationality Acts has always-been they are vehicles with which to tackle racism — the most efficient way of achieving good race relations and harmony amongst the multi-cultural communities.That is, limiting numbers allows those already here to settle and integrate. Yet in the face of overt and covert institutional racism, no effective legislation has evolved to ensure equality of opportunity. There is a history of a glaring absence of political will to tackle the discrimination faced by the Black ethnic minorities.

Britain can no longer claim that the typical Black person is an immigrant, the position is now one of second, third and even fourth generation British-born Blacks. Still Black people suffer high levels of homelessness; high rates of unemployment (particularly amongst the young — in some areas as high as 90%); and increasingly disproportionate numbers of Blacks of all ages in prisons and mental health institutions. There is a singular lack of Black presence in some strata of British society, and over-representation in those deemed of the disadvantaged. Black people now form 25% of the psychiatric population.

Studies have shown that the more stress factors a person faces, the higher the likelihood of mental breakdown. One of the crucial factors in maintaining mental stability is a condition of 'positive self image.' That the British culture is funda-mentally racist is unquestionable. Its dominant majority's attitudes and values, including colour values, are constantly reinforced and values of the Black community are seen as essentially derogatory, evil even. This produces alienation in Black people.

Franz Fanon (famous Black psychiatrist from Martinique, who trained and practised in France) saw mental illness as a consequence of social and political oppression. He wrote: 'I like many others began to suffer from not being a white man to the degree that the white man imposes discrimination on me.... robs me of all worth and... tells me that I must bring myself into step as quickly as possible with the white world. 'Mental illness further accelerates and aggravates these processes. The individual is faced with diagnostic assessment and treatment by professionals whose personal and professional reference bases are ignorant of his/her norms, and who almost certainly holds negative views of the 'patient's' culture.

Cultural factors affect mental illness in numerous ways and influence how illnesses manifest. For example neurosis and other stress symptoms vary from culture to culture and correct diagnosis is dependent on an in-depth understanding of the psycho-social stress to which the individual is exposed.

What the patient says or how s/he responds is crucial in diagnosis and the category of illness diagnosed dictates the treatment. No one can understand outside his/her cultural context, and different cultures can and do misunderstand each other, particularly in modes of expression. In the diagnosis and treatment of mental illness, the patient's most immediate feelings and familiar world are involved. Many young Blacks from a strong cultural religious background often express distress at their inability to succeed within the system in religious terms. This mode of expression is often construed as one of the classic symptoms of black schizophrenia.

Many people, under stress, revert their mother tongue. The situation, for example, in which children are used as translators poses problems in terms of parent/child relation-ships, accuracy and the finer points of translation/interpretation. It stands to reason that an extensive knowledge of the individual's cultural codes and structures is a pre-requisite for understanding and good practice.

Since there is a cultural mismatch in the professionals and those from the Black ethnic minorities they treat, it is not surprising that there are many instances of misdiagnosis. Yet the system is most reluctant to recognise this or to take on board any of the relevant steps that would effect improvement. So Blacks continue to enter, or, through, or remain in a Mental health system which assist them in maintaining mental ill health.

Evidence suggests that the demise of the notorious SUS law (used by the police to criminalise large numbers of young Blacks) has resulted in an abuse of Section 136 of the 1983 Mental Health Act (sometimes termed the Mental SUS Law). This section empowers the police to detain a person in a public place who appears to be suffering from a mental disorder and who presents a danger to himself or others. The person can then be removed and held for up to 72 hours in a 'place of safety,' — 'place of safety' being a police cell or a mental hospital.

The person detained under Section 136, more often than not, is taken to a mental hospital and held for diagnosis and treatment. Whereas

there was recourse to legal representation under the SUS law this facility does not exist under Section 136. The individual's fate is determined on the assessment of a GP, Social worker and a psychiatrist. There is access to a review tribunal, the process is however tedious and lengthy and many do not avail themselves of it. There are numerous cases of young Blacks, particularly young men who have been taken to hospital 'treated' and released after thirty-six hours (the time allowed by Section 136). The shock of the experience then takes up to three weeks to develop and become apparent.

The correlation between astronomic unemployment rates amongst young Black men and high levels of emotional disturbance in this group is not a spurious one. Nor can the relationships between the known tensions between Black youths and the police, the scrapping of the sus law and the increased usage of Section 136 be ignored.

Through research MIND discovered that amongst referrals to three places of safety in London Afro Caribbeans comprised 31% of the referrals under Section 136, but only ten per cent of the local population. Not only are disproportionate numbers of Black people admitted compulsorily under 'section', they are three times more likely to be diagnosed schizophrenic than whites. Schizophrenia is incurable and its treatment is invariably drug-based. The long-term usage of these drugs, without exception, have harrowing side effects.

Other terms connected to schizophrenia, used to describe illnesses in Black people are Cannabis Psychoses and West Indian Psychosis. Alternatives treatments to drugs, for example psychotherapy, are available within the system. These, however, are expensive and are usually offered to a selected few. Black people as a rule do not have access to these forms of treatment.

Social workers hold enormous statutory powers. The Mental Health Act 1983 gave them increased responsibilities which can include compulsory psychiatric treatment. Such social workers play a crucial role in the assessment and compulsory admissions of mental health patients.

Relatives of patients can also turn to social workers for help in a crisis situation, yet there is little or no training in ethnic cultures. Psychiatric social workers do have some specialist training, but the training is based on current research and psychiatric practices. Their assessments and treatment of Black patients therefore are identical to the assumptions which that research makes and dominant cultural norms and perceptions. Such comments as 'I treat everyone the same, regardless of their background' is not uncommon to the Black experience and is meant to convey an absence of racism. Yet implicit in this kind of statement is the notion of superiority and the expectation of the client to make all the adjustments.

Many Blacks who have been hospitalised re-enter their community at even greater disadvantage than they went in; and with little or no social work support. Being labelled mentally ill carries stigma. Families out of ignorance and because of the stigma tend to reject mentally ill members. Thus many find themselves alienated from relatives and normal peers and in a cycle of deprivation.

Homelessness is a problem, particularly for young Black men. There are no support systems for the Black mentally ill, nor are there services which offer counselling and education of family members. The Establishment's back up systems such as day centres are white orientated, consequently Black patients attending such establishments are subjected to further stress. The Fanon Project found 'the reason why a large number of 'mentally ill' Black people do not support the existing day care agencies is because of the orientation of these centres towards the indigenous culture to which they find it difficult to relate .... Their reaction to this stress situation often manifests itself in 'some form' of culturally antisocial or aggressive behaviour which is invariably seen as further a confirmation of their illness.'

Under Section 28 of the National Health Service Act (1946) Local Authorities are empowered to make arrangements for the prevention of illness, the care of persons suffering from mental defectiveness or the aftercare of such persons. Lambeth for example is a multicultural borough with 24% Black population (including those of Afro-Caribbean and Asian origins). Its mental hospitals have a Black representation of 50% and in one hospital (Cane Hill) a staggering 70%. There are three local authority day centres (with a total of 130 places) which offer support and rehabilitation for the mentally ill. There is no representation of Blacks in these centres, nor are the services extended into the Black sections of the community.

Tooting Bec hospital which amongst other catchment areas serves parts of Wandsworth, has a capacity 938 beds. The majority of beds are currently occupied by Blacks, and Springfield Hospital is burdened with an over-representation of Black patients.

Wandsworth Health Authority's document 'Adult Mental Health Services for Wandsworth and Merton — The broad framework of a service planning Strategy' (7th February, 1986) states in its introduction 1.1 'This report identifies the major areas of work that are being pursued to review, refine and establish the needs of the population we serve; highlights the uncertainties and constraints in developing a service planning strategy for an eight year period and stresses the importance of making rapid progress to develop alternative services whilst retaining the flexibility to modify the size and nature of these.' The report completely ignored the needs of the Black mentally ill. The revised report, (June 1988) is marginally better in its approach, it states: 4.4 The major uncertainties with respect to the strategy for providing a comprehensive general psychiatric service to the adult mentally ill can be summarised by four interrelated question:- .....

How should we be designing services to better meet the needs of the racial minority clients in the community and in hospital? '3.3 The major uncertainties in the development of the strategy for the elderly mentally ill are: ..... The increasing numbers of elderly people from racial minorities by the end of the century and how best to design services which better meet their needs. Credit must be given that on the back page of the report it further states: 'particular priority must be placed on recruiting staff from racial minorities given the composition of the population in the catchment area; and under 'Future training needs: Priority should be given to racial and cultural awareness and equal opportunities.'

Twenty five per cent of any system is a compelling figure, yet the needs of Britain's Black psychiatric population are persistent in their invisibility. There is a common belief that the vast majority of Black people currently being sectioned under the 1983 Act should not be in hospital at all. That the issue, rather than being a medical one, belongs in the political arena; and one of social control policy via the police, the medical and social work professions.

The following are two typical case histories:

Case Report I

D.C. is a 32 year old single female of Afro Caribbean background. She was referred to the clinic with a nine year history of chronic mental history. Her first four years of illness were associated with 12 admissions to hospital for in-patient treatment. On each occasion the picture was one of disturbed behaviour, bizarre symptoms, restlessness and the fall off in the quality of self care and her capacity to maintain an acceptable level of function.

When admitted initially the patient had a regular job, lived in her own accommodation and looked after her only child who is a boy. Within one year of admission the patient could no longer survive in this accommodation and was incapable of looking after her child. Therefore care of her child was taken over by the Social Services and the patient was housed in a psychiatric hostel. Contact between the patient and the child had been maintained, but she was not able to resume child care during the nine years of illness.

During the second period of illness, lasting five years, the patient was reported as showing a fluctuating course of illness, taking overdoses, being involved in multiple relationships with mood changes and aggressive behaviour suggestive of manic-depressive disorder. She became quite paranoid in her manner and was irresponsible, leading to the belief among psychiatrists that she was also suffering from a personality disorder.

When assessed in the psychiatric unit the main problem was the patient's difficulty in relating to others. She was suspicious and reported great distress at not having full care of her child. Her mood was angry but her personality was well preserved and there was no evidence of schizophrenic symptoms of a kind suggested by her early history and by the formal diagnosis given at the referral hospital. In order to complete the assessment a family therapy session was carried out. It was found that the patient had a difficult relationship with her mother and was hostile to her father. Seemingly the family had been unable to accept the patient's cause of mental illness. This rejection had not been recognise and integrated into therapy by the referring psychiatrist.

The case highlights the difficulty of diagnosis which might come about because of problems of communication which in this case seem to partly relate to social circumstances of the patient, her background, by race and the multiple symptoms which she presented.

Case Report 2

K.T. is a 35 year old male of Asian background. He presented to the psychiatric clinic with symptoms of depression. He complained of lack of concentration, early morning waking, memory disturbances, feelings of guilt concerning the past and a number of somatic symptoms of which headaches were the most prominent. Five years previously he presented to psychiatric services and recovered following a brief period of treatment. His symptoms had returned during the past two months when the patient could give no good reason for this relapse. The patient had migrated to Britain six years earlier along with his wife and two children. The marital relationship was difficult with the wife more dominant of the two partners.

On examination the patient showed an absence of feeling. He believed that people were talking about him, complained of ringing in his ear. In his manner he was slow and withdrawn. His wife reported that the patient had lost interest in his activities for some time but that his depressive symptom had returned gradually over the last three months.

The family live in a run down housing community and had been subjected to teasing and physical abuse by their neighbours. They had few friends in England and were assessed to be socially isolated. It seemed important to provide social support in order that the two children would not be detrimentally affected by the situation.

The psychiatric assessment was th the patient was suffering from schizophrenia. However, on reviewing the psychiatric findings reported by colleagues treating the patient previously, it was found that although they too believed that the patient suffered from schizophrenia, their diagnosis was couched in cultural terms with the result that the treatment was discontinued after a short period, and no social support was given. Further enquiry from the patient's wife indicated that during the intervening period, all members of the family had suffered because of her husband's incapacity to work normally, the reaction of the children and the fact that she was forced to work long periods of overtime in order to support the family.

WANDSWORTH COMMUNITY FORUM (WCF) in conjunction and consultation with other groups and interested parties intends to:-

a) Pressure the Health Authority to examine the above trend and to make positive responses;
b) Coin an educative process whereby members of the Black Communities become aware of the high incidence of mental illness; and in the face of illness, offer and/or use proper support mechanisms.

Contact: Icilda Dunkley WCF, 498 0618 or Marium Nafisa (Ethnic Switchboard) 682 0217/7

(Thanks to Don Kinch, Social Work Fanon Project and Ethnic Switchboard)

R.I.P. ILEA
The bulk of existing adult education provision will be wiped out when responsibility for the service is handed over from the Inner London Education Authority (ILEA) to the boroughs.

Chop
In spite of ILEAs continuing efforts to secure statutory transfer of staff in adult education institutes, it looks as though the majority of institutes will be axed when the boroughs take over. The boroughs will chop adult education because government guidelines dictate a 40% axing of existing education spending - and no statutory requirement to carry on funding adult provision.

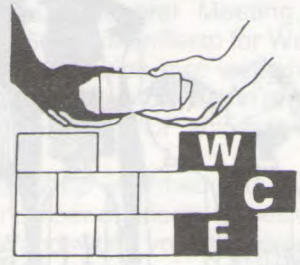
Chop
Only four out of nineteen London institutes will continue to get central government funding. Even central government funded institutes will have to increase course fees. This will mean low income groups currently benefiting from concessionary rates will be forced to pay more. Existing Equal Opportunities policies for priority groups will inevitably suffer.

Victims
The staggering impact of these cuts may be measured by taking into account the extent of existing provision. London adult education institutes cater for 15% of England's adult students. A 1987 survey revealed that the majority of students were women; almost half were drawn from ethnic minorities; most students lacked formal qualifications; 20% were retired and 6% were disabled people. Two out of every five students qualified for reduced fees and a quarter of the total were using the service to improve their job prospects. Such figures indicate that the institutes provided an unrivalled opportunity for inner Londoners who have benefited least from initial education.

Carved up
The voluntary sector will also be directly damaged by the abolition of ILEA because many voluntary groups rely on ILEA to support staffing and accommodation.
The youth service, already losing staff (not eligible for statutory transfer), are in danger of being carved up amongst a variety of borough services.

Consultation?
Wandsworth Director of Education, Cambridge University-educated Donald Naismith, is on target to finally submit borough education plans for ministerial approval in February 1989. The adult education element of what will be one of the largest Inner London education authorities will be publicly aired via an advertising campaign and a series of public meetings.

Or decimation?
The Council favours amalgamating the three institutes serving Wandsworth into one hierarchy controlled from the Town Hall. Though the Borough declares it hopes to continue to 'meet the educational needs of local residents as far as possible at times and locations which suit their circumstances', the future for local voluntary organisations dependent on ILEA support looks uncertain.
Issues associated with adult education and the Wandsworth voluntary sector will be the focus of a Community Forum workshop on December 10 - if you care, be there!



BAC Information

The Battersea Arts Centre has a large selection of distribution lists. The lists are used to inform groups about events which might be of special interest to them.
Community groups, particularly women's groups, Afro-Caribbean and Asian groups, wishing to be added to the lists are invited to write with their name and address to the publicity office at the Centre. Being on the lists entitle groups to receive posters, leaflets and information about group discounts.
Write to Battersea Arts Centre, Old Town Hall, Lavender Hill, London SW11 5TF. Tel 223 6557.

ETHNIC SWITCHBOARD

The Ethnic Switchboard is a comprehensive London wide multi-lingual interpreting, translating service — funded by the Department of Health. The Ethnic switchboard arose out of the Ethnic Study Group (Co-ordinating Centre for Community and Health Care (CCHC).

Aims and Objectives
The Ethnic Switchboard aims to:
- Promote equality of health care (physical and mental) and delivery of services among people disadvantaged by reason of race, gender, language and culture.
- Promote and evaluate a framework of good interpreting translating services and thereby develop and effective code of practice both for interpreters and professionals.
- Carry out training and research in pursuance of the above.
- Raise health consciousness among the Black and Ethnic population.

MEETING OUR AIMS
Community Participation
The Ethnic Switchboard will endeavour to forge links and encourage active participation in all areas of its activities.
Networking
To promote and develop a regional and national network of interpreters and translators.
The collation and dissemination of relevant information.

Training
Develop training programmes in accordance with our Code of Practice.

Conference/Workshops
Organise conferences, workshops and seminars on the various aspects of interpreting, translating and advocacy.
The Ethnic Switchboard is in its developmental phase and will be fully operational in 1989 and and will offer a 24 hr service.
Contact: Marium Nafisa, Ethnic Switchboard, 2B Lessingham Avenue Tooting, SWI7 8LU. Tel: 682 0216/7